



Fasenra

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at 1-844-387-1435.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: Same as Requesting Provider **HPHC Provider ID:** _____
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **Provider Tax ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Inpatient Hospital Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Drug Information:

Strength/Measure _____ Units ml Gm mg ea Un

Directions(sig) _____ Route of administration _____

Dosing frequency _____

Criteria Questions:

- What is the diagnosis?
 Severe asthma with an eosinophilic phenotype (i.e. eosinophilic asthma)
 Other _____
- What is the ICD-10 code? _____
- Is this a request for initial therapy or for continuation of therapy?
 Initial therapy with Fasentra, skip to #5
 Continuation of therapy with Fasentra
- Has asthma control improved on Fasentra treatment as demonstrated by EITHER of the following?
Indicate below or mark "None of the above."
 A reduction in the frequency or severity of symptoms and exacerbations
 A reduction in the daily maintenance oral corticosteroid dose
 None of the above

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Fasentra SGM – 04/2018.

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5. What is the patient's baseline blood eosinophil count? _____ cells per microliter
6. Does the patient have a history of severe asthma despite current treatment with BOTH of the following medications at optimized doses? Yes No
- Inhaled corticosteroid
 - Additional controller (long acting beta₂- agonist, leukotriene modifier, or sustained release theophylline)

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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